Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

FAMILY SUPPORT EXCEPTION APPROVAL

CLIENT NAME	DD NUMBER	DATE

FAMILY SUPPORT STATUS

You have been approved to receive additional Family Support
Amount: $ ☐ One time allocation ☐ Per month
Approval period (cannot exceed 60 days/two months): Begin Date End Date

CASE/RESOURCE MANAGER	TELEPHONE NUMBER	E-MAIL ADDRESS

YOUR APPEAL RIGHTS

You have ninety (90) days from receipt of this notice to request an administrative hearing to appeal this action.

☐ You are currently receiving a paid service from DDD and want the service continued during your appeal. You must file your request for an administrative hearing by: _____.

- If you choose to continue this paid service and the final decision upholds the department's action, you will be responsible to repay up to 60 days of paid services.
- If you do not want your paid services to continue, contact:

_____ at _____
CASE/RESOURCE MANAGER TELEPHONE NUMBER

You have the following rights:

1. To be represented (you may be eligible for free legal assistance);
2. To request a copy of your file and all information reviewed by DDD to make its decision;
3. To submit documents into evidence;
4. To testify at the hearing and to present witnesses to testify on your behalf; and
5. To cross examine witnesses testifying for the department.

A form for requesting an administrative hearing is enclosed.

QUESTIONS

If you have questions about this decision or appeal process, please contact:

NAME	TELEPHONE NUMBER	LOCAL OFFICE

Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DDD FAMILY SUPPORT EXCEPTION APPROVAL REQUEST FOR HEARING

Per Chapter 388-02 for DSHS hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME	TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARING (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following service decision by the Division of Developmental Disabilities (DDD).

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH
ADDRESS OF PERSON REQUESTING HEARING	CLIENT ID NUMBER
CITY STATE ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ MESSAGE PHONE

I was notified of the decision on: _____ by: _____
DATE DSHS OFFICE NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ Yes ☐ No Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
ADDRESS STREET	CITY	STATE ZIP CODE

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ Yes ☐ No

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing. Follow the instructions in the Notice of Hearing that will be mailed to you by OAH.